

TRIAL EXHIBIT 29



Medical Suitability for Expatriate Assignment History & Physical Examination

GO-146-MSEA

Mark Snookal
CAI - MVZM

RECEIVED

JUL 24 2019

*Initial
Nigeria*

0724-15

Note to Examinee and Examiner: In the US, the Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information for any U.S. based employees (whether within the U.S. or outside the U.S. on assignment) when responding to this request for medical information. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. Local or Host Country legal requirements may also apply.

Part A: Examinee: Please complete Parts A through F prior to exam:

F.I.	M.I.	Last Name	First Name	CAI	Gender
		Mark Snookal		MVZM	M

Current Job Title	New Job Title*	Current Company/BU/OpCo	Next * Company/BU/OpCo	Current Location	Next * Location
IEA Reliability Team Lead	Reliability Engineering Manager	ESE	NMASBU	El Segundo CA USA	Escravos, Nigeria

*If Applicable

Part B: Your country of assignment may or may not have full medical resources to support your health needs. Please answer the following questions as accurately as possible and check 'N' (no) or 'Y' (yes) in the column. Answers with Yes, please provide more information in the description boxes. This information is used to promote your safety and ensure your health needs can be met.

(If need, please use back page)		N	Y	Description
1.	Do you have any medical, physical or psychological conditions under the care of a health professional? If yes, please describe.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	I have a dilated aortic root. I am under the care of a cardiologist and see him once per year for a checkup. I have consulted with him on this assignment and he sees no issues with it.
2.	(a) Are you taking any medicines that require a prescription? If yes, please list.	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Losartan and Amlodipine
	(b) Are you taking any non-prescription medicines on a frequent basis? If yes, please list.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
3.	(a) Do you have any allergies?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
	(b) Have you ever had severe allergic reactions? If yes, do you know what caused it?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
4.	Do you exercise for at least 30 minutes 3 times a week, on average?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
5.	(a) Do you feel unusual fatigue or sleepiness?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
	(b) Do you have any problems sleeping?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
	(c) Do you use sleeping aids, including medication?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
6.	Have you ever experienced health problems working in extreme weather conditions?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
7.	Have you experienced unexplained weight loss or gain?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
8.	(a) Do you smoke? If yes, what and how much each day?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
	(b) Did you smoke regularly for more than 1 year ever in your past?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
9.	Do you drink alcoholic beverages? If yes, what is your average weekly intake?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
10.	Have you ever required a medical evacuation from a work location? If yes, what was the reason?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	

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		Examinee Last and First Name Mark Snookal	Examinee CAI MVZM
11.	Have you ever had any mental health or psychological issues requiring at least a medical prescription? If yes, please describe	<input type="checkbox"/>	<input checked="" type="checkbox"/> I was treated for depression with Effexor for a few years from approximately 1994-1996
12.	Have you been in the emergency room and or hospitalized within the last six months?	<input checked="" type="checkbox"/>	<input type="checkbox"/>
13.	Have you undergone any surgical procedure or operations within the last six months?	<input checked="" type="checkbox"/>	<input type="checkbox"/>
14.	Did you have a physical (periodic, preventive) exam within the past two years?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
15.	Would you need health/medical resources for any disabling or special condition in the country of assignment?	<input checked="" type="checkbox"/>	<input type="checkbox"/>
16.	Would you like to schedule a discussion with a Chevron Physician or Regional Medical Manager to discuss further a health condition or learn more about the host country medical resources?	<input checked="" type="checkbox"/>	<input type="checkbox"/>
17.	Does your new position require you to work or travel Offshore, In Field/Plant or Strictly Office? Please advise If you need additional certifications for your new position (e.g. HUET/BOSIET, Oil and Gas U.K.)	<input type="checkbox"/>	<input type="checkbox"/> My position is strictly onshore

Part C: Please answer the following questions and check 'N' (no) or 'Y' (yes) in the column. If 'Y' please describe.

Have you had any illness or condition related to the following body parts or systems? (minor conditions do not need to be mentioned)		N	Y	Description
18.	Head and Neck	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
19.	Eyes or Visual	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
20.	Ear, Nose and Throat	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
21.	Teeth (a) When was your last exam? (b) Is there any dental work pending? Please describe	<input type="checkbox"/> <input checked="" type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	11/2017
22.	(a) Chest such as shortness of breath, chronic cough. (b) Breasts	<input checked="" type="checkbox"/> <input checked="" type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	
23.	Heart such as chest pain, palpitations or irregular beating	<input type="checkbox"/>	<input checked="" type="checkbox"/>	I have PVC's which have been evaluated by a cardiologist and do not require any treatment
24.	Abdomen such as pain, hernias, abnormal bowel movement	<input type="checkbox"/>	<input checked="" type="checkbox"/>	I had my gallbladder removed in 2014
25.	Kidney, bladder or genital area	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
26.	Spine and Musculo-skeletal, movement limitations or pain	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
27.	Skin changes such as rash, spots, moles or itching	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
28.	Epileptic seizures, dizzy spells or migraine	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
29.	Diabetes or increase in blood sugar	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
30.	Anemia or other blood conditions	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
31.	Tuberculosis (TB) or positive TB test, skin or blood (e.g. TB spot, IGRA/Quantiferon®)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
32.	Any other health problems (Please use space below. If need, use back page)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	

Examinee Last and First Name

Examinee CAI

Mark Snookal

MVZM

Part D: Exposure History (Employee Only)

Have you ever been exposed at work to dusts, solvents, other chemicals or any other known workplace hazards, e.g. biological agents?

☒ Yes ☐ No

If YES, please list agents with dates and for how long:

I have worked in industrial and petrochemical locations from 1990 present

Have you ever been exposed in the workplace to:

☒ Noise ☐ Radiation/X-ray Equipment ☐ Vibrating Hand Tools ☐ Repetitive Movement ☐ Weight Lifting ☐ Other

If you checked one of the boxes above, please specify for how long, and whether Personal Protective Equipment (PPE) was used:

In my work in industrial and petrochemical locations from 1990 present I have been exposed to noise but have always used PPE

Part E: Occupational History (Employee Only)

Have you ever been part of a medical (health) surveillance program through your work due to exposure to workplace hazards? e.g. Part of a hearing conservation program due to exposure to workplace noise.

☒ Yes ☐ No

If YES, please list with dates:

I am currently in a hearing conservation program in my employment with Chevron El Segundo

Part F: Family History

To comply with the US Genetic Information Nondiscrimination Act of 2008, this part should NOT be completed for any US-based employees (whether in the U.S. or outside the U.S. on assignment). Any information inadvertently provided for a US employee in this section should be redacted if the form is to be sent to the US for filing in the employee's medical record. Local related legislation may be also applicable.

Are there any medical conditions within your family relevant to be mentioned?

Physician Comments:

Have you ever been employed with Chevron or examined for employment by Chevron?

☐ No ☒ Yes If yes, when At hiring at Chevron El Segundo in 2009**EXAMINEE:**

I certify that the information given by me is true and I authorize the examiner to furnish the results of this examination and other related medical investigation results to either the Chevron Regional Medical Managers or the Chevron Global Health and Medical facility. I acknowledge and agree that the results of this medical evaluation are managed by Chevron in a secure and confidential data system that will store and may transmit information to countries other than where the medical examination takes place, including but not limited to the U.S.

FOR APPLICANT ONLY: I understand that any misrepresentation, false statement or omission herein may result in the company rejecting my application, withdrawing any offer of employment, or terminating my employment at any time.

Examinee Signature

Date (mm/dd/yyyy)

7/18/2019

Examinee Last and First Name Mark Snookal	Examinee CAI MVZM
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Part G. PHYSICAL EXAMINATION To be completed by Health Care Provider

Vital Signs

HEIGHT ft/cm	WEIGHT lb/kg	BMI	Abdominal Circumference in/cm	B.P. (mmHg)	PULSE	Temperature ("C/F)
72"	256 lb	34.7		135/78	53	97.5

Vision

	Uncorrected			Corrected			Depth	Tonometry	Color Vision	Visual Fields
	Both	Right	Left	Both	Right	Left				
Far	20/ 6/	20/ 6/	20/ 6/	20/ 6/ 16	20/ 6/ 16	20/ 6/ 16			Normal	
Near	J#	J#	J#	J# 1+	J# 1+	J# 1+				

N	A	N = Normal. A = Abnormal, please describe	DESCRIPTION
<input checked="" type="checkbox"/>	<input type="checkbox"/>	1. General Appearance	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	2. Head	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	3. Ear, Nose Mouth and Throat	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	4. Neck	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	5. Eyes	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	6. Chest	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	7. Breasts	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	8. Respiratory System	
<input type="checkbox"/>	<input type="checkbox"/>	9. Cardiovascular System	occasional ectopics (PVC's)
<input checked="" type="checkbox"/>	<input type="checkbox"/>	10. Abdomen, Viscera/Hernias	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	11. Genito-urinary	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	12. Lower GI Tract	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	13. Extremities	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	14. Spine and Musculo-skeletal Range of Motion.	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	15. Skin and Lymphatic System	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	16. Central Nervous System	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	17. Peripheral Nervous System Reflexes	
<input type="checkbox"/>	<input type="checkbox"/>	18. Others, please specify	

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LABORATORY AND SPECIAL TESTS

N	A	Not Done	AS INDICATED	RESULTS. N = Normal. A = Abnormal, please describe
<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Audiogram	
<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Chest X Ray	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Complete Blood Count	
<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Drug Screening	
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	ECG	
<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Pulmonary Function	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Serum Profile/Chemistries	
<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Stress Test	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Urinalysis	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Others, please specify	

REMARKS: Describe significant / abnormal findings/limitations noted above (if need, please use back page)

① PVCs - frequent asymptomatic followed by cardiology
② Dilated aortic root followed by cardiology
ongoing studies yearly Echo US CT chest
stable on meds

If any abnormalities were found during the examination, was examinee informed? ☒ Yes ☐ No

Part H: MEDICAL RECOMMENDATION

H.1. Fitness for Duty Classification, ONLY FOR INTERNAL CHEVRON USE	H.2. Restrictions pertinent to Job Requirements (refer to GO-308)
<input type="checkbox"/> A. Fit for Duty	No heavy lifting > 50 lbs needs review of Recommend letter from cardiologist to clear him
<input checked="" type="checkbox"/> B. Fit for Duty with Restrictions	
<input type="checkbox"/> C. Not Fit for Duty	
<input type="checkbox"/> D. Failed to comply with requested evaluations, due to:	

Examiner's Name (please print) IRVING SOBEL MD	Signature [Signature]	Date (mm/dd/yyyy) 07/24/2015
Address 4076 ADMIRALTY WAY Street City	4th Floor MDR CA State / Province Postal / Zip Code	Country USA 1140890292

Chevron Global Health & Medical Approval (please print name)	Signature	Date (mm/dd/yyyy)
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ID #:5078

EXH 29/6

Examinee Last and First Name	Examinee CAI
Mark Snookal	MVZM

PLEASE ATTACH COPIES OF IMPORTANT REPORTS OF CURRENT INTEREST.
If available, Form GO-308 (Physical Requirements and Working Conditions) must be included.

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